PRINTED: FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155702 07/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1850 MATADOR ST CARING HANDS HEALTH CARE CENTER PERU. IN46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE K0000 The following plan of correction or K0000 A Life Safety Code Recertification and any corrective action set forth State Licensure Survey was conducted by herein does not constitute an the Indiana State Department of Health in admission or agreement by accordance with 42 CFR 483.70(a). Caring Hands Health Care Center of the facts alleged or the conclusions set forth in the Survey Date: 07/13/11 statement of deficiences. The plan of correction and corrective action Facility Number: 003130 are prepared and executed solely as provisions of Federal and Provider Number: 155702 State Law. AIM Number: 200386750 Caring Hands Health Care Center requests that this plan of Surveyor: Phillip Komsiski, Life Safety correction be considered the facility's credible allegation of Code Specialist compliance. Completion Date: 07/30/2011 At this Life Safety Code survey, Caring Hands Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. The original building consisting of everything except the West Wing was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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**UDN121** 

Facility ID:

003130

TITLE

If continuation sheet

07/26/2011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155702 07/13/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1850 MATADOR ST CARING HANDS HEALTH CARE CENTER PERU. IN46970 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE spaces open to the corridors. The facility has a capacity of 87 and had a census of 75 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/19/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: Exit and directional signs are displayed in K0047 accordance with section 7.10 with continuous SS=E illumination also served by the emergency lighting system. 19.2.10.1 I. The exit lights in question were Based on observation and interview, the K0047 07/30/2011 installed on 07/22/11 by the facility failed to provide directional signs Maintenance staff.II. All for 2 of 8 exit discharge means of egress. residents, staff and visitors LSC 7.10.1.4 requires the access to exits accessing the main hall and dining area are potentially shall be marked by approved, readily affected by the alleged deficient visible signs in all cases where the exit or practice. The exit lights in way to reach the exit is not readily question were installed on apparent to the occupants to make clear 07/22/11 by the Maintenance staff.III. The exit lights in the direction of egress to a public way. question wer installed by This deficient practice could affect 41 Maintenance staff on 07/22/11 residents on 100 hall and 4 residents and an audit sheet developed to observed in the dining room on service document a monthly audit of the hall east as well as visitors and staff who exit lights for proper functioning. This audit will be conducted could misinterpret which direction to go monthly by the Maintenance as a possible escape route out of the Supervisor or designee.IV. The

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Event ID:

UDN121

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l I		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
155702		155702	B. WING		07/13/2011		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
CADING	HANDS HEALTH O	ARE CENTER	1850 MATADOR ST PERU, IN46970				
	HANDS HEALTH C						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)		COMPLETION DATE		
IAG		· · · · · · · · · · · · · · · · · · ·		Maintenance Supervisor or	DAIL		
	facility during a fire emergency.			designee will audit monthly t	he		
	Findings include:  Based on observations on 07/13/11 during the tour between 12:27 p.m. to 2:45 p.m.			exit lights and report findings			
				the QA committee monthly a			
				on-going for any further action needed.V. Completion Date	l l		
				07/30/2011	·		
		-					
		ance Supervisor, exit					
		osted at the intersection is located to indicate the					
		o 100 hall or into the					
	l -	which both lead to a					
		d on interview on					
	07/13/11 concurr						
	observation, it was acknowledged by the						
	Maintenance Supervisor the						
	aforementioned directional exit signs should be posted to prominently display the path of travel to the 100 hall and service hall exits.						
	2.1.10(1)						
	3.1-19(b)						
V0000							
K0000							
	A Life Safety Co	de Recertification and	K0000	The following plan of correct	ion or		
		Survey was conducted by		any corrective action set fort	h		
	the Indiana State Department of Health in accordance with 42 CFR 483.70(a).			herein does not constitute ar	1		
				admission or agreement by Caring Hands Health Care C	enter		
				Carring Flarida Floatin Gale C	- CITICOI		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3		(X3) DATE S	X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		DINC	02	COMPL	ETED	
		155702	A. BUILDING B. WING			07/13/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	2			ATADOR ST			
CARING HANDS HEALTH CARE CENTER			PERU, IN46970					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE	
	Survey Date: 07/13/11				of the facts alleged or the conclusions set forth in the statement of deficiences. The of correction and corrective a	•		
	Facility Number		are prepared and executed so		olely			
	Provider Number: 155702 AIM Number: 200386750  Surveyor: Phillip Komsiski, Life Safety Code Specialist		as provisions of Federal and					
					State Law.			
					Caring Hands Health Care C requests that this plan of correction be considered the facility's credible allegation of compliance.	e of		
	At this Life Safety Code survey, Caring				Completion Date: 07/30/201	1		
	Hands Health Care Center was found not							
	in compliance with Requirements for							
	Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the NFPA							
	`	rotection Association)						
	· ·	Safety Code), and 410						
		West Wing with 27 beds						
was surveyed with		•						
	Health Care Occupancies.							
	be of Type II (22 fully sprinklered alarm system wi corridors, resider spaces open to the	acility was determined to (22) construction and was . The facility has a fire th smoke detection in the nt sleeping rooms and ne corridors. The facility (5.87 and had a census of this survey.						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/2011 FORM APPROVED OMB NO. 0938-0391

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155702	(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/13/2011	
NAME OF PROVIDER OR SUPPLIER  CARING HANDS HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1850 MATADOR ST PERU, IN46970				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE

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Event ID:

UDN121 Facility ID:

ility ID: 003130

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